§417.476 Waived conditions.

If HCFA waives any of the qualifying conditions required under subpart J of this part, the contract must specify the following information for each waived condition:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by HCFA.

[60 FR 45680, Sept. 1, 1995]

§417.478 Requirements of other laws and regulations.

The contract must provide that the HMO or CMP agrees to comply with—

(a) The requirements for PRO review of services furnished to Medicare enrollees as set forth in subchapter D of this chapter;

(b) Sections 1318(a) and (c) of the PHS Act, which pertain to disclosure of certain financial information;

(c) Section 1301(c)(8) of the PHS Act, which relates to liability arrangements to protect enrollees of the HMO or CMP; and

(d) The reporting requirements in §417.126(a), which pertain to the monitoring of an HMO's or CMP's continued compliance.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 56 FR 8853, Mar. 1, 1991; 58 FR 38079, 38082, July 15, 1993]

§417.479 Requirements for physician incentive plans.

(a) The contract must specify that an HMO or CMP may operate a physician incentive plan only if—

(1) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and

(2) The stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

(b) *Applicability.* The requirements in this section apply to physician incentive plans between HMOs and CMP and individual physicians or physician groups with which they contract to provide medical services to enrollees. The requirements in this section also apply to subcontracting arrangements as specified in §417.479(i). These requirements apply only to physician incentive plans that base compensation (in whole or in part) on the use or cost of services furnished to Medicare beneficiaries or Medicaid recipients.

(c) *Definitions.* For purposes of this section:

Bonus means a payment an HMO or CMP makes to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation means a set dollar payment per patient per unit of time (usually per month) that an organization pays a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Payments means any amounts the HMO or CMP pays physicians or physician groups for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this section.

Physician group means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Physician incentive plan means any compensation arrangement between an HMO or CMP and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid recipients enrolled in the HMO or CMP.

Referral services means any specialty, inpatient, outpatient, or laboratory